61058143

TASK FORCE TO STUDY
THE NON-GROUP HEALTH INSURANCE MARKET

MINUTES OF MEETING

RECEIVED
SEP 23 1999
MARYLAND INSURANCE ADMINISTRATION

September 8, 1999
Lowe House Office Building
Annapolis, Maryland

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ATTENDEES:

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STEVEN LARSEN - COMMISSIONER

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DONNA RIVERA, Arthur Anderson

DR. ELIZABETH SAMMIS, Vice President, Corporate Communications, MAMSI

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AL REDMER

BARBARA McCLEAN

P R O C E E D I N G S

(9:20 a.m.)

CHAIRMAN COLMERS: -- 10 minutes after the hour, and having not passed this out previously since -- vacations, we're now back here all rejuvenated and ready to get back to tackle the problems of the non-group insurance market. I'm sure everybody has gotten a copy of the minutes which are more like the hours of the meeting. The transcript is there. I don't know that anybody wants to change anything, not that you could, because I'm sure the transcription is perfect and it did actually reflect what was said, so -- don't have to approve the minutes.

Next item on the agenda would be a presentation today by Blue Cross and other carriers to discuss alternatives and options in their view of SAAC --. Sitting before us today is John Picciotto and Donna Rivera, and John, the floor is yours.

MR. PICCIOTTO: Thank you.

CHAIRMAN COLMERS: John, is that you humming?

MR. PICCIOTTO: No, not yet. I -- is someone

humming?

CHAIRMAN COLMERS: Maybe it's just me. Do you hear it? Okay. Like a dog, I only hear a high pitch.

MR. PICCIOTTO: Whining you mean.

CHAIRMAN COLMERS: Yes, I'm very sensitive to that. It's all right, John. Go ahead.

MR. PICCIOTTO: Oh, there's a lot of lines there, but in any event, thank you for, for hearing from us today as well as others. As you may remember, we were scheduled to make a presentation at the last meeting, but because of time limitations we couldn't, and that probably is better, because the presentation that we did pass out you can throw away even though it's very well done. The presentation you have before you, and unfortunately I think we, you all have copies, but there are no more available today. We will get them to anyone who needs them in the audience. This is a more complete presentation, and if I might before Donna begins try to just set the framework for what we perceive the presentation to be about. We all are

aware that the HSCRC is in the process of, has accepted a recommendation from its staff to reevaluate SAAC, to look at it to come up with alternatives or to get rid of it which is I think a fair summary of, of where we are. This Task Force, as we all know, is charged with looking at the non-group or the individual market, and in its totality, and one of the specific elements that we need as a Task Force to, to grapple with is the, the SAAC differential. What we're going to propose today is, is specific to CareFirst. It is what we believe a rationale for continuing with the differential as it currently exists. We will also be filing this with the HSCRC in the near future, a more detailed document which, which gives a lot more information. We thought for this Task Force and for this group it would be better to give a detailed summary. We will also file with this group the, the I guess 50-page summary or rationale or study or what have you.

What we would like to do is -- and you will see in the presentation that it is, it is geared to CareFirst. Our basic thought and our basic approach to

this is we believe that whatever the proposals, whether it's from CareFirst in terms of how to measure SAAC or the importance of SAAC, from MAMSI, from Prudential or any other carrier who cares to, to comment, that the basic principles that we're, we're trying to establish for this Task Force and ultimately the HSCRC is that as it looks at SAAC, it cannot just look at open enrollment, that open enrollment is too narrow a focus, that what very well could happen if only open enrollment is used to justify SAAC or to measure SAAC is that you very well could destabilize the non-group market, a market which, which we'll talk about we believe is stable in this state. We've heard some testimony in the past several meetings from summaries of other state situations, etc., and some of the things Donna will say today we think make clear that in Maryland, the non-group market is relatively stable, if not very stable, and that any significant change to SAAC while well intentioned in some respects or while maybe understandable in terms of what the industry has been unable to convince the Commission of may be a bad

public policy, and to do this in the time frames we're talking about may be throwing the baby out with the bath water. It may very well create the problem that we're all here trying to avoid.

So with that -- so what we're going to be asking the Task Force to do, to recommend ultimately, is that the HSCRC, when it looks at SAAC, because it is ultimately the HSCRC's decision to make, that it look at more than just open enrollment as a potential justification or that it look at other approaches to SAAC that we may hear about today.

With that, I turn it over to, to Donna Rivera. Donna is a principal --

MS. RIVERA: Partner.

MS. FLOYD: Partner, I'm sorry, with Arthur Anderson and has been assisting us with regard to SAAC for close to 10 years now. And my understanding is approximately 20 minutes, and then we'll, that would be obviously subject to questions, etc., and then we'll go on to the others.

MS. RIVERA: Thank you. I appreciate the

opportunity to be here today, and I'm living in Massachusetts now and really enjoy the opportunity to be in Maryland for the day. I do make frequent trips here. I always seem to find a reason to be back in Maryland.

You all should have a document in front of you which outlines the presentation that, that I'm going to walk you through and, and I'm not going to go through the details on every page, but you'll have the document for later reference. Starting on page 2 of the document, I think just to really set the stage about what I'm going to be presenting the -- what we're looking at here in terms of risk of, of uninsurance in the SAAC program are a number of different groups who have different needs, and looking at National Coalition on Health Care Report, and yesterday a Commonwealth Fund report also hit the streets, there are different groups that are at high risk of being uninsured. The young adults, the near elderly, people who work for small businesses, the fastest growing sector for employment, people who are self-employed, people with

poor health status, and probably one thing that's pervasive over all of these groups is that the highest risk group for being uninsured are low income workers and the, the Commonwealth Fund statistics yesterday showed that one-third of people under an income of 35,000 were uninsured versus 7 percent for people with an income of over 35,000. Forty-two percent of the population with an income of less than 20,000 are not offered health insurance through their job. So there are many groups here that have need of insurance, and the needs that they have are different.

If you turn to page 3, and I'm sure that most of you are fairly familiar with the SAAC program, but just to, to highlight some of the, the origin and some of the findings that have occurred in the past, back in 1974, the HSCRC adopted a differential for Blue Cross based on their underwriting practices, and in 1986, after years of, of hearings and discussions, a decision was issued that defined SAAC as comprehensive coverage with low self-payment provision provided to high risk individuals or groups at prices sufficiently low to

enable individuals and groups to purchase it and that the SAAC program should encourage third-party payers to participate in certain underwriting practices that would provide coverage to individuals and families that might not otherwise be insured or might be underinsured. So looking back to that prior page, those are the groups that are likely to be insured or at high risk of being underinsured or not insured at all.

Briefly to talk about the Blue, the Blue Cross program, the CareFirst program, got to get the, the new name on the tongue here, the, the SAAC program, back to the very beginning and the inception of the program, has always been broadly focused on the underwriting and business practices in the individual insurance market. So what, what we're telling you today is not a new wrinkle that, that was invented along the way. This is essentially the program that was in place when HSCRC initially granted the 4 percent discount, and in the last set of hearings in 1993, the HSCRC indicated that Blue Cross was doing a better job

in 1993 than they were back in 1974 when they were granted the initial 4 percent discount. CareFirst is the primary insurer of individuals in the state, and I'll show you some statistics on that, and a leading participant in the SEGO program with more individuals and, and groups of one and two. CareFirst incurs adverse risk selection on broadly stated over its entire book of business with higher case mix, higher level of chronic illness and higher old age groups in its book of business.

The Maryland environment, and one of the things I'm, I'm doing in Massachusetts, which is where I live now, is tracking on a national basis what is happening with the insurance market, and I will certainly tell you and have some, some stories in here that we've collected on a national scale of what's happening in other insurance markets with individual and small group products, and you should be pleased that Maryland is in a much more stable and better condition than the other marketplaces. And last but not least, and a change in the SAAC program or a major

reduction would certainly have an unfavorable effect on the premiums and the individuals covered in the Maryland marketplace.

On the next page 5, and I'm not going to go through this in detail, but CareFirst has a number of products that are offered to the individual market and, and they meet the needs of different categories back on page 1, and there is one product called open enrollment, but within the definition, each of these products are open. The employees leaving group coverage have the, the opportunity to, to convert to a long-term, affordable product under the automatic group conversion, so that's open to that group, and that is particularly targeted at that 45- to 55-year-old high risk group. The low to medium risk individuals, and that talks about health risks, are probably the highest risk individuals of being uninsured because of low income. That product is, is open to, is open year-round but is underwritten. However, it's the most affordable product and really meets the needs of a lot of the individuals in the low income range that we

looked at on the other page. High risk individuals are, are served through the open enrollment product, and CareFirst also has products for special populations, child only and student policies.

On page 6, just to give you a quick view of the number of individuals which CareFirst serves, the individuals in 1998 are 90,000 nonsupplemental, and nonsupplemental basically means that they're full insurance products not a supplemental Medicare type product, and, and SEGO members being the small group plan includes 12,000, just over 12,000 individuals of one group and about 15,000 with a group size of two. CareFirst average group size is 3.82 compared to all other competitors of 6.02, so even in the SEGO marketplace, CareFirst is serving a larger share of individuals in very small groups. And looking toward the, the bottom of the page, the estimated market share of the individual market is about 62 percent for, for Blue -- for CareFirst.

UNIDENTIFIED MALE SPEAKER: Question.

MS. RIVERA: Yes.

DR. SAMMIS: If you don't mind.

MS. RIVERA: Sure.

MS. RIVERA: Back on the other page where you described all of the products that CareFirst is offering, is it not true that the, that the, what's unique to CareFirst separating out normal commercial carriers is the special populations, the student-child arrangement and the SAAC product? I mean COBRA is required for, is federal law as I understand it.

MS. RIVERA: That's not the, the only unique product offering. The, the group conversion goes beyond COBRA, so at the point that COBRA ends, someone can continue on with a group conversion product indefinitely, and while there have been some additional requirements what -- with, with HIPPA, what HIPPA really hasn't done is to put a price cap on some of the products that might be offered to other people beyond the COBRA period. So, so for example, somebody might be able to get a product beyond a COBRA period, but it might be at a cost of $8,000, so even if they could get it, they couldn't afford it, and this, this product

continues to, to offer beyond a post-COBRA period. It has about 8,000 enrollees, and a lot of them do tend to be in the older, in the older age group, the 55 to 64 age group where, where people have struggled to get alternative insurance at affordable prices.

The, the other group is certainly the, even with the low to medium risk individuals, there are not broad product offerings available for those individuals in the marketplace, and at the premiums that they are offered at by the Blues plan and with the indemnity product and the quality of the indemnity product that is offered in that marketplace is very high compared to other folks' offering any products in that marketplace at all. A lot of, a lot of carriers just don't have any indemnity product for individuals. So that product to does have a unique aspect to it.

Moving to page 7, to talk a little bit about the underwriting practices in general of CareFirst, and one of the, the things that's not broadly available are statistics that compare age and health status of, of the enrollees of different health plans, but what we

have done here is to take the Health Services Cost Review Commission data and look at the admissions of all of the health plans compared to CareFirst, and basically what you will see is that CareFirst being in the, the blue bars on this graph, if you look in the age groups of 46 to 64 where the costs are the highest, CareFirst has a higher proportion of cases and therefore enrollees in those age categories. So you can see that, that CareFirst is getting a higher proportion of the older age population that is at risk of being uninsured or underinsured.

Then on page 8, we've taken a look at it a different way which is to look at case mix and chronic cases as an indicator of, of the health status of the individuals enrolled with the, the CareFirst plans, and if we set the, the statewide HMOs other than the CareFirst at a case mix index of one, then the CareFirst, CareFirst group is 14 percent more costly on average than the HMO enrollees or 6 percent on average more costly than other commercial carriers' enrollees, again indicating a higher disease mix and higher number

of chronic cases, and on the right, we looked at the, the same data another way and classified the cases as, as chronic based on ICD9 codes.

MR. HAMPTON: I assume these case mixes and chronic cases are for all Blue Cross --

MS. RIVERA: Yes.

MS. THOMAS: Including Medicare and Medicaid.

MS. RIVERA: Oh, I'm sorry, no, not -- these are all -- these are not including Medicare and Medicaid. These are just for the commercial, just for the commercial Blue Cross market.

CHAIRMAN COLMERS: -- ASO --

MS. RIVERA: Yes, they include, they include all Blue Cross cases including the ASO.

CHAIRMAN COLMERS: And does it -- I know it's in the footnote, it doesn't include Eastern Shore or Western Maryland. Is there a reason for that? Maybe it was only for Montgomery, Prince George's and also southern Maryland I believe --

MS. RIVERA: The, the reason -- there, there was no reason to exclude those counties other than that

the bulk of the enrollment are in the counties that are listed here, and we were doing finite detail work with the, the data and trying to make sure that we were focusing on the, the, where the preponderance of the, the individual and group business was, so it's just a matter of numbers.

MR. HAMPTON: Of the percent of chronic cases, are those weighted based on percent of market share? How are, how are those determined?

MS. RIVERA: They were determined based on looking at the, yes, the percent, the number of chronic cases divided by the total number of cases for that particular carrier, so CareFirst, 24 percent of CareFirst's cases are chronic. Eighteen percent of the HMO cases would be classified as chronic and 21 percent of commercial, so they're all, they're all weighted with a denominator that makes them comparable. So it's not a market share. It's a pure percentage of how many, what percent of my cases would be classified as, as chronic.

MR. HAMPTON: Okay, thanks.

DR. SAMMIS: And, and can you rule out the, the -- is it, is it hypothetically possible that some of the difference that you see in case mix and particularly in distribution of cases by age cohort could also mean that perhaps Blue Cross is not as efficient in utilization management as some of its competitors?

MS. RIVERA: Well, that's a good hypothetical question that I've always wanted to bat around with the, with better data, but I actually have looked at CareFirst age cohorts, and I've actually done work in looking at age cohorts inside of Milleman and Robertson underwriting, and I know for a fact that, that CareFirst age cohorts are in fact higher than the Milleman and Robertson underwriting averages for, for the area. So it could be theoretically possible, but I don't think it is based on the other information that I've looked at, and we're always looking for --

DR. SAMMIS: But it could be a factor.

MS. RIVERA: It could always be a factor.

MS. FLOYD: Of course, Beth, if you listen to

the MHA, we're, we're doing a much stronger job than other carriers.

DR. SAMMIS: You have a good public relations department.

MS. RIVERA: So that, that gets us to the, the end of the, the data, and just to summarize what the, the data on risk selection on chronic cases shows, certainly demonstrates that, that CareFirst is subject to adverse risk selection, does underwrite, does insure an older and sicker population than other insurers in the state, and going back to the original intention of SAAC, this is definitely consistent with part of the reason that the SAAC program was established and part of the reason that Blue Cross was granted that initial 4 percent discount.

Before kind of getting to, to some of the final recommendations, just a brief review of, of some of what is, is going on in other states, and there are lots more, lots more stories that, that could be added to this list, but there, there is certainly a significant problem with individual insurance and high

risk pools occurring in other states now with, with New York and Washington State, California, Florida with Humana exiting the entire individual product market, the small group market in Texas, the folks in Maine who are going to get a 27 percent increase after their 48 percent increase last year, and I think that what you've got here with the, the individual and, and even the small group market is a much more stable situation than we're seeing in lots of other parts of the country. And, and I will say that in other parts of the country, more is yet to come in terms of, in terms of some of the problems.

Just to give you a sense of how much CareFirst is spending care dollar wise on some of the populations that we're talking about, individual nonsupplemental is 97 million. SEGO is approximately 290 million. The adverse risk selection, and this is just for the inpatient hospital piece, so you can probably double that if you consider the impact on the total cost to the CFS is 28.9 million based on our calculation. Those are, are some cost figures to look

at associated with these high risk populations.

Kind of in summary, on page 13 and the page 14, some recommendations, the, the major change in the SAAC program that would reduce it would result in higher premiums, fewer options and ultimately increased hospital bad debts, but probably worst of all a decrease in the individual market stability which seems to be better here than some other places, and what's being recommended here is that on page 14 is that, is that you ask HSCRC to continue evaluating SAAC based on broader, the broader original intent of the program and the broad program that, that Blue Cross had in place back in 1974 when it was initially granted the discount, that you use a, that you develop and use a broad set of criteria based on quantitative and qualitative measures. Some potential criteria are listed here. And that last but not least, to really focus on making no changes to the SAAC program that will destabilize the, the individual market here in the high risk insurance market. That's a summary of the, the Blue Cross position and some of the statistical

information that, that CareFirst brings today.

Other questions, comments?

CHAIRMAN COLMERS: Questions? Ms. Thomas.

MS. THOMAS: How much of your business that was charted here is ASO business on that, on that chronic chart?

MS. RIVERA: I can't tell you how, how the ASO business divides out here, because that, that data is not -- to separate out the ASO business is not readily available. This data comes from the Health Services Cost Review Commission, and there is no -- the hospitals do not and Blue Cross or CareFirst does not have a marker, if you will, for the ASO business.

MR. PICCIOTTO: Generally, Alex, for the business at large, just checked with our underwriter, approximately 50 percent of our business is ASO business. As Donna said, whether that translates into 50 percent of this, we don't know, but it is half of our business generally.

MR. LARSEN: One of the questions I'd like to ask, I guess assuming, as we will, that all data that

you presented is accurate, Blue Cross has a large individual market, which we know that they do, and it's generally a higher risk, higher cost market, I guess what I'm, I didn't hear and thought I might, maybe I'm headed in the wrong direction, which is what, what is the correlation between what Blue Cross is doing and their market share and practices in this market? In other words, I know that they collect premiums from individuals and the individual market, and I know that, you know, Blue Cross has come in now and again for rate increases, and you know, in my simple mind, I've always thought of SAAC as somehow as serving as some type of subsidy for these products, that only with SAAC could they be able to do this, and what I, what I haven't seen here at all is that, is any correlation other than saying we have these high cost individuals that we get through open enrollment, but we charge premiums to those folks, and they certainly pay a heck of a lot more than folks in the group market. So what's the correlation between the SAAC product and what Blue Cross is doing however admirable and desirable it is?

MS. RIVERA: Well, there are a number of things. One is that in terms of the, the cost of the, the chronic cases, I mean those are distributed broadly through, through their population and do drive up their costs compared to other carriers, and the SAAC program provides funding to partially offset that cost. Not even half of that cost, if you consider, or approximately half of that cost if you look at just that one piece of excess cost from chronic cases, the SAAC program would cover approximately half of that cost. If you look at the individual marketplace, the individual premiums, the, the measurement is, is substantial, available, affordable coverage, and if you look at the individual marketplace, and if you actually had the opportunity to look at low to medium risk individual premiums, and you will in the, the full document filing, you would actually find that those individuals are being insured at lower than the group rates. So they are being offered insurance at lower than the group business rates for, for Blue Cross. The high risk --

MR. LARSEN: There are individuals that are getting cheaper insurance than the, than the group rate?

MS. RIVERA: Than groups, yes.

MR. LARSEN: For comparable products?

MS. RIVERA: Yes, I mean even after you make all of the adjustments, they are very, they are lower cost --

MR. LARSEN: Well, now that's data I'd like to see, because I know my actuaries are, are skeptical of that, because we've looked a number of numerous rate increases in the last, last year. I mean I think that those issues become critical to what SAAC does for Blue Cross. That's --

MS. RIVERA: Those, those individual products are very reasonably priced, and that particular product where it's a very popular product, and it's very affordable to the low income individuals compared to other things in the marketplace. Very good product, very, very low premiums.

MS. WHITE: Can I, can I interject?

MS. RIVERA: Sure.

MS. WHITE: Unless I'm missing the boat here, the non-group individual product is underwritten and, and that's why I've always explained to clients who are incredulous that the, you know, that the group rate is higher than this individual rate that they've called about, I -- it seemed to me -- it's always seemed to me that it's lower because of the underwriting or the ability to underwrite.

MS. RIVERA: That, that would certainly be part of the reason. It's certainly a low age group, and it's a group with a lot of turnover, so some of those factors could contribute to the, to keeping the premiums low there too. Also the, the administrative costs that, that CareFirst has are low compared to the other folks writing individual insurance, and if you measure the differential of CareFirst underwriting or administrative costs compared to other individual insurance writers, it affords about $16 million more of care dollars for individual insured populations out of this group.

So those are some of the things that the, the SAAC is, is really enabling, enabling CareFirst to do. The high risk individuals and the, the high risk individuals have a direct premium reduction as a result of the, the SAAC program as well. So the dollars are being used in a variety of, of manners to, to create the product mix that serves the needs of the different individual groups that are at high risk of not having insurance or being underinsured as well as providing for high risk populations that are broadly in the CareFirst mix.

CHAIRMAN COLMERS: Marilyn.

MS. MALTSBY: Donna, on page 4, one of the examples of criteria that, that you cite here is cross-marketing of open enrollment and other individual products. What would be CareFirst's response or your response to taking a similar approach in the individual market that the State of Maryland took in the small group market in terms of underwriting and community rating and that kind of thing?

MS. RIVERA: The -- I personally think that

there is an advantage to maintaining some separate pools, and the reason is that the biggest barrier to insurance is affordability, and if you start blending these groups then you don't really, you really start to lose some of the affordability for the low income groups that can come in through that, that can come in through that underwritten product that's open enrollment year-round. It's underwritten, but it's open year-round, very affordable. You start blending that, and some of the ability to keep that price down goes away. So, so I would not recommend blending those groups, and I would also recommend making sure that the product for that particular group stays a little bit less generous than your small group product, because it will start to, to affect the affordability factor if you put all of the benefits in. That particular product has, has lower drug benefits and a few other lower benefits than your small group product, and they would have a pretty significant factor of driving the cost up.

MR. CAVANAUGH: John, one of the things that,

that is a controversy is what is the original, what is the authority of the Commission to do something like SAAC? You and I have talked about this in the past. Do you still agree that the authority of the Commission to do anything insurance related has to link back to possible costs?

MR. PICCIOTTO: Yes.

MR. CAVANAUGH: And averted bad debt.

MR. PICCIOTTO: Right. And in response to Commissioner Larsen's question, as of now, and of course the Task Force and then the legislature ultimately writes on a clean slate so, so anything is possible, but, but the -- as we understand since day one the HSCRC's authority and, and what SAAC is intended to do is to reflect hospital costs, and to the extent the HSCRC believes a carrier or set of carriers is doing something from an underwriting or enrollment standpoint that results in lower hospital costs, i.e. averted bad debts or whatever that term of art is, that that's the extent of the HSCRC's authority. Now, now we, you know, we may choose or the legislature could

choose to change that, but that the, the, that that's the sole focus of the HSCRC -- it's the Insurance Division, Commissioner, excuse me, administration, excuse me, who determines what the rates will be that a carrier can charge.

MR. CAVANAUGH: I think the, the Commission's current -- and what -- you just said, I've heard many of the arguments in this presentation before. What's somewhat new is the argument about adverse selection, and I'm trying to make the linkage between adverse selection and what you and I agree is the, the link back to the averted bad debts that needs to exist, we brought out a minute ago that the, the way you quantify adverse selection includes probably ASO business, so maybe half of that is ASO. And when I think of that, if you have a higher risk group in ASO, that isn't a problem to Blue Cross so much as it is to the employer, because any higher costs are simply passed through the employer. Is that correct? I mean the nature of ASO is --

MR. PICCIOTTO: Yes. Well, the, the answer

to your second half of your question is yes, that is that by definition ASO, it's the, it's the group's money.

MR. CAVANAUGH: Then I think of other large groups that may have insurance through CareFirst that aren't self-insured, that are insured through your -- and I'm having trouble thinking of a really large group, any group over 50 that has insurance that may be a higher risk group that somehow got insurance from Blue Cross that couldn't if Blue Cross said we're out of this business. Go to another carrier as a large group and get a -- I mean if they're going to get experience rated to the degree the new carrier can, but they're probably going to get coverage. Would you agree with that or not?

MS. RIVERA: There, there are employers that, that preclude people from participating in their programs for a period of time based on pre-existing conditions, and those are not really the types of programs that, that CareFirst offers, so you know, part of it goes back to that those types of, of practices

and making sure that we're encouraging the employer market to, to offer from day one to people who have, who have those types of medical conditions, and now with health premiums going up 27 percent and 30 percent and 10 percent, we may see some more of that type of action too.

MR. CAVANAUGH: So they may have some trouble getting coverage from another carrier. They may get some employees kicked out for a while, but they're going to get coverage eventually I would guess. And I think that another chunk of your business would --

MR. PICCIOTTO: But -- excuse me.

MR. CAVANAUGH: Sure.

MR. PICCIOTTO: We'd like to -- I think that there may be situations in which certain types of businesses either aren't solicited by other carriers or there's -- and again, I'm not an expert on this, and I don't pretend to be. We'd like to, if we could, provide a little more detail on that in terms of the, the marketing efforts and, and what we do versus the competition.

MS. RIVERA: In, in the meantime, they could be uninsured and producing bad debts, so while they were waiting to be covered, and the, the new Commonwealth Fund --

MR. CAVANAUGH: The entire group or some employees?

MS. RIVERA: The people with, that were at the highest risk of, of uninsurance which would be the, those with chronic conditions in that particular situation. So you know, if you look at the Commonwealth Report, those just coming out, they're citing a statistic of 17 percent of uninsured or underinsured individuals being fair or low, fair or poor health status.

MR. CAVANAUGH: I think some of the higher acuity that you may have would also be in your small group product, but of course, small group can jump --

COURT REPORTER: Just a moment.

MR. CAVANAUGH: -- for your open enrollment, for your, to any other plan. So I guess -- and then you have some of the higher acuity medically

underwritten, so while they are higher acuity, it is past medically underwritten. And then some of your high acuity is in your enrollment probably where in the absence of an open enrollment product those people probably would be uninsured. And I guess the large point I'm trying to make is you've offered an argument that Blue Cross or any carrier that has, that insures these higher risk groups should receive some benefit through SAAC, and I'm questioning whether just the fact that they're higher risk means that they're otherwise uninsurable. Clearly it's not true in the ASO business. We bicker a little about large group and the small group that are otherwise insurable, and they're medically underwritten and by definition whether they're higher acuity or not, they're somehow past medically underwritten. So I'm not sure how much of that amount you'd quantify when your adverse selection really is ultimately traced back to people who would be otherwise uninsurable. Again it's bad debt.

MR. PICCIOTTO: The -- also, I think, I think you're probably -- I mean I think that's a good point

in terms of whether or not the full load should be counted or credited or whatever you want to call it. I think that it's not unreasonable to, to say that part of it should be. I think the other thing we might want to consider or should be considered is, is the concept of underinsurance. That is one of the reactions of, of an otherwise insurable group that, that Blue Cross, that leaves Blue Cross may be that they need to cut back on coverages, etc. And again, there are a lot of reasons why they might otherwise do that too, but I, I think clearly the lion's share of it should be --

MR. CAVANAUGH: I'd like to make two more points. First, on page 4, one of your bullets says the loss or substantial reduction of SAAC for CareFirst would result in higher premiums, fewer covered individuals, high -- and increased hospital beds. First of all, would you agree that the higher premiums would be for CareFirst enrollees that we -- if, if for some reason SAAC were to end, not just for Blue Cross but across the board, premiums would go up for some groups, but wouldn't over time they come down --

certainly for other groups who no longer paid the hospital markups --

MS. RIVERA: Large groups and the Medicare program will get a tiny break, and individuals would get, would end up on the short end of the stick with the potential for some fairly substantial premium changes, so it would reverse the, the favorable or potentially reverse the favorable program in terms of individual rates.

MR. CAVANAUGH: Thank you. And based on, Donna, the calculations you made, I added up roughly 102,000 individuals with Blue Cross to 90,600 in individual products, and then you say about 12,000 in small group over --

MS. RIVERA: With group size of one and, and some more for group size of two.

MR. CAVANAUGH: So Blue Cross's entire book of individuals is about 102,000, and if I remember correctly, the SAAC enrollment was about 4,000 for that. Does that sound right?

MR. PICCIOTTO: The open enrollment

enrollment.

MR. CAVANAUGH: Open enrollment. I'm sorry.

MS. RIVERA: Yeah, I was going to say I would count them all as SAAC enrollment. The, the one --

MR. CAVANAUGH: Open enrollment -- 4,000.

MS. RIVERA: -- the one product that's labeled open enrollment has, has I think it's about 4,000 in it.

MR. PICCIOTTO: Somewhere in that -- I think it --

MS. RIVERA: About --

MR. PICCIOTTO: -- it may be 3,500. Thirty five, in that neighborhood.

MS. RIVERA: And it should be pointed out that they're being bombarded with mail about making sure that they examine all of their other options in case they want to convert out of that to one of the other products as well, so even after they come in through that door, CareFirst is offering the opportunity to apply for the, the individual underwritten product if they, if they can qualify for

it.

MR. CAVANAUGH: One last question. I scoured the commission's files and have no, no -- everybody agrees with your history of SAAC that Sid Green (phonetic sp.) made this calculation. I can find no record of the calculation itself.

UNIDENTIFIED MALE SPEAKER: It was done on the back of an envelope.

MR. CAVANAUGH: I, I -- do you guys have the envelope here or --

MR. PICCIOTTO: Gary, the, the urban myth about that I guess is that, that they were, and again, we may have someone who was there in the audience, but is -- I'm not sure there is a piece of paper. We'll, we'll scour our file as well and see.

MS. RIVERA: I think the 1986 hearings, someone said if it, if it were so high, then there would be a parade of people running in to sign up for the SAAC program. So it must not be too high. Maybe it's too low at that level because there is not a, there hasn't been a long line to sign up for it.

MR. LARSEN: There is now unfortunately.

MS. RIVERA: Longer.

MR. PICCIOTTO: Longer, yes.

MR. LARSEN: I know that there is in the old Insurance Administration building a, in the corner of one of the floors a small shrine --

MR. PICCIOTTO: They should have bronzed his, they should have bronzed his desk with all the files that he's --

CHAIRMAN COLMERS: Donna, I have a question about the information that's on page 12. One of the things that you mentioned where Blue Cross should be given credit is the participation in the global insurance market. Certainly one of the things that changed the small group from 1993 to today was the change in '95 to allow the self-employed individuals to participate in the small group market, and because those individuals can participate either in the medically underwritten non-group market or in the small group market, the presumption is that those who are self-employed would do so in the small group market

only if they could not pass medical underwriting in the non-group market. Is that correct?

MS. RIVERA: If the consumers were totally aware of everything, they might do that and, and then again, they might not so --

CHAIRMAN COLMERS: Well, the only way in which they can enter self-employed individuals in the non-group -- in the small group market, I should say, is during open enrollment period. So if they came to you at some point other than the open enrollment period, you presumably would tell them well, you can buy insurance from us over here -- but of course, as Sean points out, that is something that's available to other carriers who participate in the small group market. Are you suggesting that you measure, that some of the measure of benefit that Blue Cross provides to the, in order to receive SAAC -- the SEGO which should only be that portion of SEGO that is to the groups of one, perhaps you are in your groups of two? Are the numbers that are on page 12 for SEGO hospital costs? Are they total costs, and are they for the entire small

group, or are they for only those groups of more than two?

MS. RIVERA: They are the total medical costs, and they are for all group sizes. The groups of one and two, the total cost for the groups -- the total medical costs for groups of one and two are approximately 43 million.

CHAIRMAN COLMERS: Forty-three out of the 289.

MS. RIVERA: Yes.

CHAIRMAN COLMERS: And if we use your rule of two to one that you talked about earlier about the chronic care, then the hospital piece for groups of one and two would be about 23?

MS. RIVERA: That, that would be --

CHAIRMAN COLMERS: Or 21?

MS. RIVERA: -- that would be a rough estimate.

MR. LARSEN: There may be other questions. Beth Sammis has to leave at 10:15, and I'd like to maybe reserve the right to have you guys --

MR. PICCIOTTO: Sure.

MR. LARSEN: -- if you can be here come back, but I'd like to give Beth a chance to come up and address the group, and then when she's gone we can talk about her.

DR. SAMMIS: Thank you.

MR. PICCIOTTO: An old MAMSI trick.

DR. SAMMIS: -- Beth Sammis. I'm a Vice President of Corporate Communications for MAMSI, and I'm here to talk --

UNIDENTIFIED MALE SPEAKER: The new, improved MAMSI.

DR. SAMMIS: The new, improved MAMSI, and I'm here to talk to you today about some of our views of SAAC which not surprisingly will mimic some of what CareFirst has already told you. And I thought today to talk about six things, one of which was the history of SAAC, but I think that CareFirst covered that relatively well, so I'll skip that and go directly to what we see are the public policy goals that have been achieved by the SAAC program. And we would concur with

CareFirst that the SAAC program has brought stability in the non-group market and that it has brought affordable coverage. We would also concur that the SAAC program has made it possible for individuals to have coverage available to them that would not otherwise be available in the non-group market. And the SAAC program has done that largely because of the incentives that are available to us as SAAC carriers which I'm sure all of you know, most of you know is a 4 percent differential on inpatient and outpatient regulated hospital costs, and that is an important point that I want to bring up later, that it is a differential and not a discount as Hal and John have imbedded in my brain forever so that the most that a carrier can earn as a differential is anywhere between, is up to 6 percent, 4 percent for the SAAC program, 1 percent for working capital, one percent for prompt pay with Medicare and Medicaid always receiving the 6 percent lower cost at any hospital.

Well, what the incentive has done for us as a company is to encourage us to act like a Blue Cross

plan, to encourage Optimum Choice to act as an insurer of last resort. We were faced, as all carriers were, with the prospect of having to decide what to do once the federal government passed HIPPA legislation whether to remain in the individual market or whether to exit. We exited the market in our indemnity company, our PPO product sold through MAMSI Life and Health Insurance. We don't participate in the individual market in any state except in Pennsylvania where there is an alternative arrangement, much I think along the lines of what Golden Rule will advocate for the SAAC program so that in Pennsylvania we're not subject to guaranteed issue for HIPPA eligibles.

We exited the market in Optimum Choice in many states, but we did not in the state of Maryland largely because of our ability to be able to obtain the SAAC differential, and so we have stayed in the individual market in Optimum Choice on both a medically underwritten basis and on an open enrollment basis. And we believe that that has offered some degree of choice to individuals, that there is a product

available to them not just from a Blue Cross plan but from another carrier as well.

Moreover, we think that the incentives that were provided to us as a carrier when we entered the SAAC market gave us an incentive to do some cross-subsidizations that are not a feature of the SAAC program as it exists today. We were told by the commission when we were given the open enrollment product that we had to reach a certain critical mass of individuals in that product, or we had to continue to hold quarterly open enrollment periods, and of course, we would run the risk of not keeping the discount if we didn't substantially increase the number of individuals covered. And so we made a decision in January to markedly reduce our rates which substantially increased the number of people, surprisingly, who purchased the product and increased the number of people who have purchased that product again in July, and not surprisingly as well, we have seen a significant increase in our loss ratio in the SAAC program as a result of the decrease in the premiums.

So we think that the public policy goals have been achieved, that those incentives have been, have encouraged us as a carrier to act in a way that is more aligned with those public policy goals, but we also know that there is a cost to this program, and the cost is, is that because this is differential and not a discount, the cost, the decrease in what we pay for hospital care is subsidized by those commercial insurers and self-pay individuals who enter a hospital and receive services. So in effect, we have taken a subsidy from others to ourselves to be able to meet the public policy goals, and we believe that it is fair for the State to ask whether or not the costs that are being borne by those other groups are appropriate to the incentive that we are receiving to stay within this product.

So we have a slightly different view of how to solve this problem. I think we concur with CareFirst that it would not be in the State's interest to, to dissolve this program. We do believe that it has offered Maryland an alternative that is unique in

the country, and I must say that one of my first jobs was a staff person to the other insurance commissioner, Ed Muhl, who had to have, had been given the task by the General Assembly to have a study group on whether or not Maryland should establish a high risk pool, and the SAAC market came out of that, out of that Task Force as well with glowing colors about why we didn't need a risk pool. So we've had a long history in Maryland of looking at the SAAC product and always concluding that, in fact, it should be kept, but I think this is the first time in which it was really asked whether or not the costs and the incentives are in line.

So here is our solution. We think that in order to be able to restore fairness to this, that it is appropriate for the HSCRC to look at establishing a fair incentive, a fixed percent like we have now for the value of the differential, and we don't know what that fair percentage is, if it's 3 percent, if it's 4 percent, if it's something, whatever it is. We don't know. And second of all, we believe that it is also

appropriate for the HSCRC to encourage cross-subsidization of premiums by establishing a cap on the value of the differential for any carrier in the market, and that could be a flat dollar cap, or it could be a cap based on how many enrolled lives you have in the SAAC program. And if in any given year a carrier exceeded that cap that was preset on a, on a, or set forth in some sort of a formula that a carrier would know on an annual basis, if you exceeded that because you didn't appropriately lower the premiums to make them affordable, the carrier would be subject to paying the excess over the cap, and that payment we would propose would go either to the HSCRC directly to giving grants to hospitals to fund uncompensated care or to the Health Care Foundation to help subsidize programs to cover the cost of the uninsured.

I'd be happy to answer any questions.

MR. CAVANAUGH: Can you, can you describe again the, the second part of this proposal, the cap, and maybe you could just throw some hypothetical numbers out there in terms --

DR. SAMMIS: Say for instance that this year the value of the differential for us would have been past, that the HSCRC determined that in point of fact, $2 million was a good enough incentive for OCI to stay in the market, and I'm not saying that that's in fact true, but just hypothetically, so let's say that the value for us this year was 2 percent, and quibbling over the value, so forth, the value is 4 million for us. We would have to pay $2 million to the HSCRC or to the Health Care Foundation for this year, because we exceeded the value that was predetermined on an annual basis.

MR. HAMPTON: How, how would that be determined, just by the number of people you take through open enrollment or --

DR. SAMMIS: No, I think -- we don't have a lot of money to hire high priced consultants, so we have an internal policy group, and we're not really sure how to establish that. We figured that the HSCRC was far more clever than we were and that they would be able to come up with a complicated formula that we

could all agree on, partly because we don't understand it.

MR. LARSEN: That, that formula is what, is what the HSCRC would determine you would need in order to write this business, is that --

DR. SAMMIS: What a carrier would need. One of our other principles is that whatever the incentive is for one carrier to remain in the, in the market is the same incentive that every carrier should have to remain in the market, because the purpose of this program is not to give one, an upper hand to one carrier over another. It's really to encourage all carriers to act like the insurer of last resort.

MR. LARSEN: But how -- what is your definition of this incentive? Is this something that is applied to a single product? Is it --

DR. SAMMIS: The incentive is, is -- we see the incentive as remaining more or less along the lines of what it is today which is a fixed percent differential for all inpatient and outpatient regulated hospital costs.

CHAIRMAN COLMERS: So, so just to follow that out, what you would do is each year calculate in advance what MAMSI's entire expenditure for hospital services were.

DR. SAMMIS: Well, not MAMSI, just OCI, because we're not in the other --

CHAIRMAN COLMERS: OCI, and calculate from that what 4 percent of that would be so that you would identify what the, the value that you received. Absent that, you would be paying 4 percent more, so that would be the --

DR. SAMMIS: And I think there's a stretch here. The HSCRC through Sean was able to come up with a test of how to evaluate the value of the differential for each carrier, and that was a certain amount of money. We then supplied the HSCRC with the amount of money that we spent on hospital care costs for our SAAC population. The difference is the value of the discount or the differential to us, and so it is appropriate for the HSCRC to take the next step which is to develop a formula for how one decides whether or

not the value that a carrier has earned in this market is appropriate for the costs that are borne by others in the system, and that's where we would urge the HSCRC to spend its time.

CHAIRMAN COLMERS: One last question. You mentioned that you had to lower your premiums in order to meet the standards that were placed on you when you received the differential, and you talked about the loss ratio for your SAAC product. Could you share with us what the loss ratio is for your SAAC?

DR. SAMMIS: The last time that I checked it was running over 300 percent.

CHAIRMAN COLMERS: And how do the premiums there currently compare to the prior premiums that you had on your small group?

DR. SAMMIS: I have no clue. We -- Delegate Redmer asked us a question similar to, to provide similar data to him on our small group market as Blue Cross has been able to provide, and I think they are more sophisticated than we are. We don't track the group size of our small group market members. We made

a business decision that we didn't need to know that in order to be able to set community rates, and so we just don't track it.

CHAIRMAN COLMERS: But I wasn't asking about only the small, the small of the small group. I was just asking premium comparison --

DR. SAMMIS: I don't know.

CHAIRMAN COLMERS: But you could find that out.

DR. SAMMIS: I could. Would you like me to?

CHAIRMAN COLMERS: Please.

DR. SAMMIS: Although I'm not sure that the benefits are comparable, but I could find out for you the, the premium for the, the new benefit plan that we have assumed has been approved by regulations and are getting ready to market in January. I could provide you with that in the small group market which is, you know, a takeoff of the --

CHAIRMAN COLMERS: Right.

DR. SAMMIS: -- comprehensive standard health benefit plan, so it's perhaps more comparable, and they

are very similar to what our current rates are.

MR. CAVANAUGH: How, how big is OCI in comparison to all of MAMSI?

DR. SAMMIS: OCI is our largest carrier in the risk market.

MR. CAVANAUGH: But risk and non-risk, is it half of all of MAMSI -- more than --

DR. SAMMIS: Probably.

MR. CAVANAUGH: Half.

DR. SAMMIS: Yeah. Yeah. It's the flagship company.

MR. PICCIOTTO: Beth, I'm, I'm missing something in terms of the connection between the proposal and hospital costs. The theory is -- I may be missing it. The theory is that the HSCRC would determine how much a carrier, how much a carrier receives by way of differential, and then make another calculation as to how much it needs to continue to offer the products. Where do hospital costs fit in and, or do they? Maybe they don't. I --

DR. SAMMIS: Well, you know, I think that

one -- hypothetically, one could take the test as it was laid out this year in terms of the value to each carrier in the SAAC market and then decide how to measure whether or not that value is an appropriate enough incentive to remain in balancing the costs, because all of us were earning a certain amount of money that was more or less akin to our market share within that, within that coverage and so there, the, the value was approximately the same to all of us on a, given our relative market share. So I don't think it's a stretch then to, to talk with the, for both SAAC carriers and non-SAAC carriers to talk with the HSCRC about how to determine what does it take to keep us in this market, because clearly, all of us face a greater adverse selection, a greater uncertainty.

We've had a number of people enter this product who have needed rather catastrophic health care services, stayed with us through those health care services for maybe a month or two and then canceled, and so there is a certain amount of, of risk that you're taking on that's unknown, and in order tc keep

us in that market, there needs to be some incentive. I, I think that has always been recognized by the HSCRC. Now whether or not the value of the discount should include both what we avert in bad debt and charity care, because we've kept people out of the hospital and sent them to AM-SURG centers or to physicians' offices for preventive services, I think that's another discussion again on a technical basis with the HSCRC about how to determine the value to each carrier. I would agree with you that, that just to look at, at what we have averted on the hospital care side is not an appropriate way to, to look at what we might have averted on the bad debt side from the hospital, because particularly in an HMO, the whole assumption is, is that you get people into other sites that are more appropriate for the care rather than letting them walk into the hospital when they're at their sickest point.

MR. PICCIOTTO: So the -- I may be a bit slow, but the answer then I think is that it really doesn't have to do so much with what actual hospital

costs may be as a result of these programs but a general feeling that, that as a public policy principle, we want carriers to continue to offer in this case open enrollment --

DR. SAMMIS: Right.

MR. PICCIOTTO: -- so the HSCRC decides how much you and we need to stay in the program.

DR. SAMMIS: Right. They -- you know, we have a flat differential just like we do now, and we have to meet a test at the end of the year, and if we meet that test, great. If we don't meet the test, we give the extra money that we've earned back to the State to do good works.

MR. PICCIOTTO: Now I know what that little heart over the I is for.

CHAIRMAN COLMERS: Any other questions?

(No audible response.)

CHAIRMAN COLMERS: All right, thank you.

DR. SAMMIS: Thank you. I'm sorry I have to leave.

CHAIRMAN COLMERS: It would be helpful if you

would, at some point, put your proposal in writing -- I know we'll have it in the record there but --

DR. SAMMIS: Well, that's fine. I mean to be honest with you, I always thought that the most appropriate place for this dialogue was really with the commission, which is why we didn't put it in writing, but if you're asking us to do that, I can go back and do that.

CHAIRMAN COLMERS: Yes, I am asking. The next item on the agenda is really quite appropriate -- oh, I'm sorry. We have one last SAAC carrier -- two. Two last --

MR. SMOLARZ: Two that have come together recently in fact.

CHAIRMAN COLMERS: Yeah, that's right.

MR. SMOLARZ: Hi, I'm Mark Smolarz, Director of Business Operations with Prudential HealthCare, a member company of Aetna U.S. Health Care, and with me is Stephanie Williams who is the capitol region's counsel for Aetna and for Now Care (phonetic sp.) and who is here to make sure I added a member company of

Aetna U.S. Health Care.

As I think most of you know, Prudential was acquired by Aetna just about a month ago, and while we have not had a whole lot of time in the last month to talk about both Now Care and Prudential's participation in the SAAC program, Stephanie and a lot of other folks within Aetna support the letter that was sent on July 9th to Mr. Colmers that I believe everybody around the table has. It is a short letter. I will just summarize it and not get into a lot of the background or, or policy issues that have been discussed already by CareFirst and MAMSI.

My first comment and very important comment which, in fact, both John and Beth were talking about at the end is the impact of managed care. In the calculation that is done, it is a pretty much one-to-one kind of relationship. Here's a 4 percent differential, and here are hospital savings, and if the two numbers kind of equal, then we all go back home and, and put our feet up on the desk so to speak. Unfortunately, as we mentioned before, managed care

hopefully reduces the amount of hospital costs, so there needs to be a factor in considering that as part of this calculation, and if we go down the path that Beth had proposed, I think we need to build that into the calculation, and I believe in my, in, in the letter that I proposed, well, in fact, I didn't even put a number out, because I was too scared to put a number out for that, but in a separate letter to Bob Murray at the HSCRC which Sean got a copy of, we proposed a factor and showed how the calculation would have been adjusted accordingly.

And I go into talking really about the total costs, and I think we all know about how HMO manages care for members in that, you know, we don't want the member just popping up in the ER of the hospital to get all their care. We hope that the member would go to their PCP to get preventive treatment and avoid those trips to the hospital, and we think again there should be a factor considered as part of this calculation.

The other issues, as you know, insurance is a very cyclical kind of product, and it seems clearly

when you look at the most recent year for the four carriers, it certainly was not the best year in terms of looking at the comparison of those two numbers. If you look back though over time, I think you'll see clearly in Prudential's case that we have justified the 4 percent differential when considering a cost factor or even looking at it on a one-to-one basis that we come pretty close in justifying it over the years, so we think that it shouldn't just necessarily be a 1-year type of look back, but maybe look at a 3-year trend.

We also think that you should look at each carrier separately, not as a group necessarily, and I don't think that would be administratively burdensome to hospitals who need, who already have to keep track of all the various discounts by, by payer.

Another option would be to establish parameters around the premiums that are offered, because the number of members that are enrolled in this program is a key part of this calculation, and as Beth said, as she gets greater enrollment, her loss will increase, and therefore she'll come closer into

justifying the 4 percent differential.

And then finally, we think that this issue should be viewed in part of a bigger picture which is I think the HSCRC is going through a reinvention project, and this should be part of that project as well. And, and finally, we would just be delighted to work with everyone just to ensure that affordable coverage is available to the uninsured. And we can answer any questions you may have.

CHAIRMAN COLMERS: Questions?

(No audible response.)

CHAIRMAN COLMERS: Thank you very much. We did, we did have a letter -- Mike, do you want to take a few minutes and talk about what you sent us?

MR. HAMPTON: Sure, can I do it just here? Is this --

CHAIRMAN COLMERS: You can do it right there.

MR. HAMPTON: Very briefly, we, we agree with everybody else. We think SAAC needs to stick around. The concern we've got though is that we do believe that 4 percent is a little bit high and so we, basically we

think the differential needs to be looked at and reevaluate where that needs to be, and Beth's proposal may be viable. We offered a proposal to the commissioner that maybe at the end of the year, you simply look at the losses on the people that are SAAC eligible, and then each year evaluate what the percentage should be based on that. The other thing is we think maybe we should look at improving the benefits, make it a little more level across the board. Maybe the small group health benefit plan is an option. We're not really wedded to anything like that.

And finally, we'd like to see the SAAC program become the HIPPA alternative mechanism. Right now, individual carriers like Golden Rule do have to guarantee issue coverage to people that have used up all their COBRA. However, we don't get any benefit by taking those people, so we believe that putting those people over into the SAAC program may be a more appropriate way to handle that. Additionally, I think overall the cost for those people would probably be lower in the SAAC program than in the general

individual marketplace. So those are basically the three items we'd like to see incorporated into the SAAC program.

CHAIRMAN COLMERS: We did receive your letter. We didn't have a chance to circulate that among the members. We do have a copy of it. I can make sure that a copy is distributed to all the members --

MR. HAMPTON: Okay, thanks.

MR. LARSEN: We could -- why don't we, at this point, take a 5-minute break? When we return, the second half of the meeting I would like to have, we would like to have a discussion with the Task Force essentially about where we go from here. You have, should have received a list that John and his staff put together. It relates to issues market reform, and you also have a copy of our charge. I think at this point, it's a good time to regroup and give ourselves some direction in terms of where we go.

(Whereupon, a short recess was taken.)

CHAIRMAN COLMERS: In the interest of getting

out of here at a reasonable hour, as Commissioner Larsen pointed out before the break, included in your packet today was a copy of a section of House Bill 43 which lists the charge to this Task Force as well as a set of draft issues for this Task Force to consider. What Steve and I would like to do today would be to, first of all, remind everyone what it is that we're required to do under the law, check it off, and to find out what work we need to do in order to complete the background material and the findings of the group and then to begin a discussion of what the issues are that we put on the table for consideration in coming up with our recommendation that's due to the General Assembly in December of this year.

Going to the House Bill 43, beginning on line 24 on page 12 of the bill, we're to review and study the characteristics of the non-group market including an analysis and survey of non-group products available in the state, the demographics of those insured in the non-group market, the affordability of non-group products and pricing considerations and trends in

premium costs for non-group products. I think some of these we've accomplished and others we have not.

MR. LARSEN: I, I think that for the first couple meetings, the large book that we got, the review by our staff, HCACC staff, covers a number of these items in terms of a survey of the products and jumping down to the affordability. We're going to -- our staff is going to work on synthesizing this large volume of information we got relating to the pricing issues and the product issues in a form that hopefully will provide in a couple, one or two pages some comparisons, and hopefully that will give everyone a comfort level that we, in fact, will have come as close as we can in the time allotted to, to make this kind of comparison and an analysis.

The demographics, correct me if I'm wrong, John, is one of the more challenging issues. I think we're going to rely as much on national studies as Maryland-specific information. We do have a survey that's going out that Alex put together that covers some of these issues, so we do have a survey in terms

of lives covered under various products to give us somewhat of a snapshot in terms of where the distribution is of individuals in which products in the market.

So I, you know, I think by the next meeting we'll hopefully have a better sense distilled down for the Task Force members of what we've done in each of these four areas, but I guess it would be my opinion, thinking back to the meetings that we have, that although the Task Force may conclude that there are pockets of areas that we haven't hit as well as we might, and there will be time to fill those pockets that we've done a basic job of trying to cover all of these things. It just hasn't I think really been synthesized for the group at this point. John, do you concur with that?

CHAIRMAN COLMERS: Yes, I do.

MR. PICCIOTTO: In terms of the recommendations, I think that's where the statute was somewhat more vague, and really the charge that we had was, is captured in lines 33 to 36 which is essentially

based on its analysis, whatever that might be, we should recommend whether changes should be made to State laws governing the non-group market taking into account then the next page is a list of, of issues or products depending on how you view it, HIPPA, SAAC, small group, health insurance coverage for self-employed. And I think it's responding to this second piece that we might want to turn to this list that John and his staff developed which I think is a great kicking off point. Before we do that, are there any questions about the first half of our charge which is doing this review and study of the characteristics? Marilyn.

MS. MALTSBY: You mentioned the, the survey that's, and the process regarding the, the number of lives. I guess the question is there any way we can get at, and I think the carriers -- like this, people who have tried to get into the system who have said it's too high and I can't, and these are the reasons why I haven't gotten to this -- that seems to be a missing piece that those who either couldn't afford it

or were denied or what have you, and do we have a sense of that? I mean it gets back to the question of what's the magnitude of the problem, and how do we get our arms around that?

MR. PICCIOTTO: Well, I mean I think part of the magnitude of the problem you try to get at by looking at what's available in national statistics. We know that the bottom line is that there are between 600,000 and 700,000 people who do not have health insurance in the state, and I think part of it is to try to winnow out from that those people who are working in a group environment where they're not purchasing insurance where it may be available to them, winnow out those who may be eligible for government subsidized insurance whether it's Medicaid or the CHIP (phonetic sp.) program that are not availing themselves of that option and try to get back down to out of that 600,000, how many are folks who potentially could be purchasing insurance in the non-group market but, but are not. But I don't know of any way of getting at in the direction that you've asked where you go to the

carriers and say how many folks have said we'd love to buy insurance from you, but it's too expensive.

UNIDENTIFIED FEMALE SPEAKER: But Marilyn, I did ask in a survey what the number of applications received for Maryland contracts were and then how many contracts were issued, so I think we'll get some kind of sense.

MS. MALTSBY: I think, I think we need to have some number and how we, we, whatever assumptions that we use to arrive at that if we could at least have some number that we can kind of, kind of build a picture I think as part of our report, I think it would be helpful.

CHAIRMAN COLMERS: Any other questions? Yes.

UNIDENTIFIED MALE SPEAKER: I'm just going to comment that I don't think we can get that number and, and to specifically refer to the data that Alex mentioned, for those -- individuals that aren't purchasing it because they can't afford it, those are probably individuals that were declined because of medical reasons and if, if someone is interested in

health insurance and they don't buy it because of cost, it never gets to the carrier. That, that information is given to, you know, Christine or some other broker. It never makes it to the carrier level.

UNIDENTIFIED FEMALE SPEAKER: That's true.

MS. MALTSBY: Could the broker community provide that even --

MR. REDMER: I don't think most, I don't think most brokers keep track of the people that they, that they talk to about a product and, and they say no, I don't want to do it. It's too expensive. I mean you could probably get some kind of data, but when you look at the number of brokers out there and the number of people that don't buy something, you know, I think it's going to be so inaccurate that it's probably not going to be worth discussing. I, I think the, the end result is, from my perspective, if we have 600,000 that are uninsured, you know, we can assume that there is a small percentage of people that just aren't interested because they don't care about insurance, and there are a certain number of people that don't have it because

they can't get it because of health reasons. You can probably assume that the majority of what's left are not buying it because they don't want to pay the price, or they can't pay the price.

MR. PICCIOTTO: And there is -- I mean Donna Rivera mentions there are studies out there that talk about income level and connected with the percentage that have insurance, less likely, more likely, and I think that's probably as close as you're going to get. It's almost like you could make an intuitive argument that there are a certain percentage of people who can't afford it, certain percentage who don't want it.

MR. LARSEN: I, I agree, Marilyn. I think that the, kind of the resources and the time, you'd probably have to have a full-blown, you know, study over a period of, you know, a year or more to try and capture that elusive piece but important part of the data.

CHAIRMAN COLMERS: We may be getting some information. I know that we're have included some questions on the behavioral risk factor survey which is

a survey that goes out each year to individuals in Maryland on insurance status, but I don't think we'll get to the question of affordability for the folks who don't have insurance. I mean ultimately, in other states that's how they do it is they do surveys of the population which ain't cheap.

MS. McCLEAN: We do have some information from Deborah Shelay (phonetic sp.) who presented here last time from Alkacenter (phonetic sp.) that we'll incorporate --

CHAIRMAN COLMERS: Okay. Well, then the, the next point is to talk about these issues, and although Steve gave us the credit for putting this together, we did sit down with him and his staff to, to go over the list and fully expect that the group here will change it radically as, as you go through it. We have no pride of authorship here. But just going through what we've seen in the law and the discussions that we had here, the first that seemed to us threshold question was have, has it been determined whether the non-group market is in fact broken and in need of some sort of

repair, and there may be some who would argue that status quo is perfectly fine, and certainly some might say that in comparison to what's going on elsewhere we shouldn't change anything and just leave well enough alone. I think that ought to be a question that should be debated by the group based on the facts that are before us and our experience in the presentations we've had.

A second set of questions is really related to getting to what the charge of the, the group is. As Steve points out, the enabling statute is a little vague in that respect, and so another threshold question is what is our charge? Is it our charge to look for ways to expand coverage, to take a bit at the 600,000 or 700,000 folks who are uninsured, or is it more narrowly to look at providing a safety net for the uninsurable who -- purchase insurance in the non-group market or don't have it available to them elsewhere, or is it to do both? Can you do it as a combination of both? I don't think again the statute gives us direction. I think we have the flexibility, if we want

to, to focus our attention on either one of those two or, or both.

If the answer to the first question is that it needs repair, should we take a global approach, that is to say look at the entire individual market and redesign that along the lines of what we had seen last time that they have done in New Jersey, other examples might be New York, of where it's worked. I know there is some debate about whether that's been successful or not. You know, but that is an approach that we could take.

Another approach is to do an incremental approach, that is to say build on the reforms that we have seen in the small group market and extend some of those, some or a portion of those to the non-group market. And among those lists could be community rating or a standard benefit plan, discussions about pre-ex limits, guaranteed issue or renewal. And again, do you apply these to all non-group products, some of those to non-group products or what? Or do we just do a laser focus on SAAC based on the premise that we, we

can't do anything else and just focus on, on that.

And finally, we listed, again not meant to be in any way exhaustive or exclusive of one another, other alternatives that we may consider. Create a high risk pool in the non-group market as they have in other states in lieu of SAAC. Mandate the carriers that sell in other markets also sell in the non-group market. If you want to participate in the small group market, maybe you ought to participate in the non-group market. Subsidize the non-group market through other markets. I mean part of that is what SAAC does, but are there other mechanisms in which you can think about doing that? Think about looking at the tax structure. I know there are limits to what you can do on state tax incentives, but there may be following along what the federal government may be considering as part of the tax package nationally, if they don't adopt that, do we do something separately here in Maryland for the tax treatment of individuals purchasing health insurance? Do we say we don't expect the private market to act as the insurer of last resort? Do we follow an approach

that's been done in other insurance markets where we have, in the automobile market where the State has become through, through MAIF the insurer of last resort? And F, which is a little bit along the lines of what was up in 3 earlier, creating a single standard non-group product.

Now you'll note on the list here I have not included any specific proposals for SAAC. I mean that is -- that can be done in, in combination with 3C or, or elsewhere under the, under the other options. We've heard some proposals today to, to consider. And again, really the point of today's discussion is up to now, the Task Force has basically heard information. Now is our first chance to begin to hear from you as members of the direction that you think we ought to take to give us some idea of where you want us to proceed so that we can begin planning the next set of meetings for the Task Force to begin to develop recommendations to make to the General Assembly by, by December.

Do you want to add anything?

MR. LARSEN: Well, no, I was, you know, I can

at least start off some of the discussion with respect to 1 and 2 and I, then I would just be interested in hearing everyone else's impressions about all of these issues. With respect to 1, has it been determined that the non-group market is broken and in need of repair? I think that, that is a good question to ask in light of whether, what changes we're supposed to recommend. I think given some of the testimony we heard from the consultants and the complete disruption that some states have experienced with their individual market I think it's, my impression is that although we may think improvements can be made in access and affordability in the individual market, I also think it's fair to say that we're not, our market is not in the same condition as many of those other states which have gone through some of the reform measures that we then heard about such as New Jersey, and I know we didn't hear about Kentucky, but if you follow the individual market at all, you know that Kentucky is a state in complete, or was in a complete state of disarray. And my, my own perception is that our individual market can be

improved but is not at the point of breakdown that it has reached in other states, and to me, then that leads to the conclusion that we may not necessarily need as radical a change to our market than other states have pursued in order to fix it, and you know, my own, my own view is that, you know, whether it's through some combination of, of SAAC and other measures to expand coverage and affordability might be at least what I've seen so far the direction that I personally might want to go. I'm not sure that some of the other major changes out there whether those are solutions in search of a problem or whether we risk more disruption than improvement depending on what we did, and that's just kind of a general perception that I have. I would like to, as John has mentioned, we both mentioned earlier, we do need to focus on the SAAC issue but maybe take the SAAC concept and see whether we can accomplish more with it consistent with, with the role of the HSCRC and the rate-setting process, but it is a unique funding source in a sense. It's not free money as we know. It's a differential that, that ultimately gets spread

out among the other payers, but it is a system in place that we've heard, you know, that allows us to do some things that other states have to use other mechanisms to achieve, so that's just kind of a 30,000-foot overview of what I think I, I, where I stand on, on 1 and 2 anyway.

MR. REDMER: I agree with everything that, that you said. I would like to throw out a couple of other issues that, that are on there. I, I guess that one is the relationship between the non-group market and the self-employed individuals from small group -- I, I think they should be looked at together.

The other issue is, and I don't know whether we should address it, but I think we need to at some point look at it so that we're not acting in a vacuum and, and that is to see where the other Task Force is in discussing the private sector option for the children's health program. I, I know that there is discussions and recommendations that are going to come out of one and, and there might be a role for the non-group market in that as well.

MR. LARSEN: I think those are good points. I think particularly the, you know, the private sector option if you can view this, this grid moving from complete public subsidy to those who qualify for the public programs to, you know, a higher percentage of the poverty level where there is a, you know, maybe a premium payment but some subsidy and then moving into what, what is next available to people who may have insurance problems through the purely private market and how is that subsidized. You can kind of, at least in theory, conceive of a seamless web of coverages depending on where you fit into that grid and knowing what the Private Sector Option Task Force is doing would be most helpful.

CHAIRMAN COLMERS: Well, having not gone to the meeting yesterday but having heard about it, apparently they are getting to the point where the, the number of lives that would be available under the private option, based on some fairly decent studies, looks like it's pretty darn small, and you may have coupled with that the administrative difficulties for

the employers, the carriers that having a private auction might be problematic. They are, however, looking at the possibility of expanding the CHIP program, and they looked at it in terms of the populations up to 235 percent of poverty

MR. PICCIOTTO: For the families of children who would, who qualify for it.

CHAIRMAN COLMERS: Right. Currently it's for families, for kids and families up to 200 percent of poverty, and potentially expanding it up to 235 percent of poverty adds additional lives. The analysis that they are looking at is do you do that under the current MCO program, or do you do that under the private option, particularly for those above the 200 percent of poverty.

MS. McCLEAN: Is that kids only, or is that kids and families?

CHAIRMAN COLMERS: Kids only.

MR. HAMPTON: Now they said the, the employer -- best case scenario the estimate was the best, the best that the employers could expect to do

was help 1,700 kids. Non-group market was a little bit better, but it was pretty low. Was like 4,000.

MS. MALTSBY: Steve, I would agree with you in terms of Maryland not being in as bad a situation in the non-group market as some other states. But there are still some access and affordability issues that we need to address and, and in light of that, I would view the charge of the Task Force as both A and B, expanding coverage and ensuring a safety net. I'd like to see us continue to hammer away, if you will, at some options or how we can both expand insurance coverage in the, in the market. So that takes us to looking at the products and, and I think I would like to see us address, at least come to some resolution on many of the questions that are presented in the report which I think then directly back to expanded coverage and, and assuring a safety net. I think we'd be remiss if we didn't do a more comprehensive focus and would suggest a focus --

MR. LARSEN: Are there any, based on what you've heard so far, of the options under 4 that you're

prepared today to say well, I think we ought to at least focus on X or Y or, or no? And I'm certainly not trying to tie people down. I think that we do need -- and one of the options that John and I discussed was if there is general consensus with respect to what we're dealing with under questions 1 and 2 and perhaps under 3 that a smaller group, or could be the community, the whole, but a smaller group could sit down and try and thrash out a couple different options for consideration for the larger group to, to take up later this month when we have our next meeting. That's certainly not meant to foreclose any of the options but simply that it's sometimes difficult in this kind of setting to simply just plow through, you know, the options.

CHAIRMAN COLMERS: To me it gets back to the how, how broke is broken, and I still don't have my arms around that enough. I mean is, is it broken because, is it broken because there are, are pricing issues, and I can't afford it, or is it broken because there are marketing issues or, and I'm just not sure that I'm on the same page as everyone else as how

broken the Maryland system is and so what, what it is that we need to target. It's like I can't say that let's, let's look at the whole rating piece right now because I'm not, while I think pricing is an issue -- I think it is an issue, I don't know that we've all -- pricing is an issue and this is an issue, this is an issue, this is, and therefore we need to target our meetings there. So I can't be more specific than saying we ought to go up to high risk pools. That's -- I don't think that's something that I have on my agenda in any event but -- so I guess I need some clarity as a group as to what, what are we saying is broken, and how broken is, is Maryland's system and what, what it is that we're really targeting?

MR. LARSEN: Well, I'm wondering whether pulling together the information in D in a form that might give at least more of a snapshot than we have sitting here today, you know, might facilitate more of the discussion. It's not going to get, you know, we're not going to be able to get that basic information that I think you've appropriately identified as which would

be the most useful is exactly who is the population, and what exactly is the problem. Knowing --

MS. MALTSBY: I was thinking in -- I'm sorry for this -- that some matrix that's, that kind of even looks at the pros and cons of that or how it would affect Maryland's system might be helpful to us as we try to -- our discussion. You know, what are the implications of a high risk pool in Maryland's -- and have that as a talking sheet for us, if you will, to kind of look at, lay out the pros and cons and what the impact is on the system or, or will it fix anything in Maryland's system, that that might be a good talking point for us.

MR. LARSEN: In other words, take the options that we've heard about, the experiences in other states and trying to --

MS. MALTSBY: And, and some of the options that are listed here.

MR. LARSEN: I think that, that would be a good approach.

MS. MALTSBY: Either -- or we can rule out

this list from 8 up and say and this is not something that we're interested in right now and, and come up with a list that we're interested in exploring.

CHAIRMAN COLMERS: I guess one of the other problems that we've had and the reason that we wanted to put this set of issues out there is that we do have the deadline to make this report in December. The focus needs to be at least initially to be focused on the SAAC product, and yet if SAAC is not to continue, if that were one of the conclusions that either because the rate setting commission can't come up with a mechanism that the carriers agree to participate under, then we have to be thinking of alternatives. That is one thing that is unique here is we do have a mechanism for people who are uninsurable otherwise to, to purchase insurance. In terms of the timing of all of this, I think the, the SAAC issue really is sort of fundamental and getting a grip on that. And so the thought was to really have to lay out a lot of the options beyond SAAC and try to reach some conclusion on that in time for this interim report, because they are

very much interrelated.

MR. REDMER: I think the staff has done a great job with outlining some of, of the issues, but before we debate them, I think maybe as a, as a group what we need to do is, is reach a consensus as to what, if any, are the specific problems that we're going to try to address. As an example, if we look at access, well, as far as I'm concerned with, with the small group product that's out there and with the SAAC program as it exists, we've got plenty of access and, and I don't know that that's a problem now. Are people able to buy the level of benefits that they want in the marketplace? I don't know. That may or may not be a problem. Is price something that we need to address specifically as a problem? We can make those decisions, but I think if we're going to solve some problems, we need to know specifically which ones we're going to address before we offer any solutions for them.

MS. MALTSBY: That's kind of -- my question of how broke is, what's broken. What are we defining

as broken and how -- broken?

MR. LARSEN: When are the survey results supposed to get back from the carriers?

(Asides.)

UNIDENTIFIED FEMALE SPEAKER: Yes, the 24th.

(Asides.)

MR. LARSEN: One, one idea that might help us almost to track this thing, to stay on our schedule with respect to the SAAC deadline, which we kind of concluded was hard to do in isolation, would be for, for the staff of the MIA with, with HCACC to pull together in a format that, that will be hopefully revealing all of the information that we have under D that's been presented to us in terms of what products are out there, what some of the price comparisons are that will at least give people a picture of, you know, what you have to pay to get individual product, how it compares to the group, what type of coverage you get, and at the same time for, still have whoever is interested sit down and focus on the SAAC issue, and come back with one or more SAAC proposals so that at

the next meeting, we can at least have progress on defining what the characteristics are and therefore maybe what some of the problems are and perhaps compare that with one or more of the SAAC proposals and see whether there is a, at that point a deficit between what we can do with the SAAC product and what we might think, based on the preliminary analysis, what some of the products are so that, you know, we're still moving forward on the SAAC product. At that point, if we determine that gee, we still really don't have enough data on the bigger picture, then so be it, and we'll have to gather that information, but I think it might be useful to compare at that point here is the data we have. Here's at least what we can do on this first stage which is SAAC, and gosh, is that enough? Or maybe if we tweak SAAC to make it newer and brighter and better, if that's possible, that maybe can address most of the problems we see over here with SAAC, or we conclude that SAAC just doesn't have the capacity to deal with what we think is happening here. Is there any objection to kind of two tracking this? Start,

start the evolution or the development of the SAAC proposals and then also discuss kind of what this demographic information that we have is going to show us?

MS. McCLEAN: Steve, would you like us to also break out how SAAC is now as opposed to how SAAC is proposed to change under the regulations that we're looking forward, because a lot of these positions --

MR. LARSEN: Yeah, I think, I think, you know, I think to have in front of us, you know, a brief summary of, you know, SAAC, what the numbers were. We saw the, you know, numbers that had been bandied about about the $30 million and the $3 million, but you know, spend as much time thinking about what it is, how we can tweak that, because I think at that point we need to have a pretty serious discussion about ways to make that correlation more acceptable given the constraints of what the HSCRC wants to see and then what we're trying to accomplish with access and affordability.

CHAIRMAN COLMERS: I think the, the only other thing I would add to that is that in the, in the

interim, as people look at what the options are, I know it's difficult at the end of a 2 1/2 hour meeting to be fresh with your ideas, we did get some under other options, but to ask that people send those in writing to, to Steve and to me so that we can include those on a list and provide an updated list again for the next time we meet in preparation for not the next meeting but the meeting after.

MR. LARSEN: Now every time -- John and I did identify some dates, because I know that there was an issue relating to notice for today's meeting for which we apologize, and I'd like to share those with you and hope that they work for your schedules. The next meeting would be on September 29th, although it would be in the afternoon rather than in the morning, and I don't know if there are any preferences, you know, of a 3 to 5 type of approach. And I guess we try and do it here, although we'll have to check. I don't think it will be a problem. And then a meeting on October 12th in the morning which this, this is not a Wednesday, right? The 12th is a Tuesday?

UNIDENTIFIED FEMALE SPEAKER: Tuesday.

CHAIRMAN COLMERS: Yes.

UNIDENTIFIED FEMALE SPEAKER: In the morning.

MR. LARSEN: In the morning, and then the 19th in the morning. So hopefully that will let people coordinate their schedules at least for the next 6 weeks.

So we'll start to pull this, this material together, and we'll do everything we can to get you something prior to the next meeting so that you have an opportunity to look at it, so you're not seeing it for the first time when we gather on the 29th.

CHAIRMAN COLMERS: And in the interim, you had talked about perhaps a small group getting together.

MR. LARSEN: Right, right. If you're interested in participating in the SAAC project, please give John or I a call, and that will be scheduled probably in the next, you know, well, 2 weeks at least. All right. I guess that's it.

CHAIRMAN COLMERS: Oh, yeah, one other

announcement I wanted to make, and that had to do with vouchers for travel expenses. Barb, you want to update the, the group on what you had told me?

MS. McCLEAN: There has been a question raised on how we're going to deal with compensating you for your mileage, travel expenses. Rather than doing it at each meeting, if you think it's appropriate what we would do is have you keep track of it and then in December when our interim report is due, we'll have everybody submit one filing, then we'll do it again at the end of the fiscal year, the end of June, and then since this group continues until December of next year, we'll do it again. So rather than submitting every month, we'll do it three times if that's okay with everyone else.

CHAIRMAN COLMERS: Thank you.

(Whereupon, the meeting ended at 11:30 a.m.)

C E R T I F I C A T E

This is to certify that the foregoing transcript in the matter of: TASK FORCE TO STUDY NON-GROUP HEALTH INSURANCE MARKET

BEFORE: JOHN M. COLMERS, CHAIRMAN

DATE: SEPTEMBER 8, 1999

PLACE: BALTIMORE, MARYLAND

represents the full and complete proceedings of the aforementioned matter, as reported and reduced to typewriting.

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